

# Pre-Surgical Patient Questionnaire

**Section 1:** Patient or Office Staff Completes – (Check the appropriate boxes)

Who will be driving the patient home after surgery? \_\_\_\_\_

At what number or hotel can we reach the patient the day before the scheduled surgery?

Phone: \_\_\_\_\_ Hotel: \_\_\_\_\_

BMI: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_  
 \_\_\_\_\_

- Yes  No  Does the patient have an allergy or sensitivity to LATEX?
- Yes  No  Does the patient need an interpreter? Language \_\_\_\_\_  
 Family  Language Line  Sign Language
- Yes  No  If the patient uses a wheelchair, can he/she transfer to a cart with minimal assistance?
- Yes  No  Can the patient sign his / her own legal documents?  
 POA: \_\_\_\_\_ Telephone: \_\_\_\_\_
- Yes  No  Has the patient or any of his/her family ever had an adverse reaction to anesthesia?
- Yes  No  Is the patient a Diabetic?  
 Yes  No  Is the patient on Dialysis?

**Cardiac History**

- Yes  No  Pacemaker?
- Yes  No  Internal Defibrillator?
- Yes  No  Open Heart Surgery?
- Yes  No  Stent Placement?
- Yes  No  Congestive Heart Failure?
- Yes  No  Heart Attack?
- Yes  No  Irregular Heart Rhythm?
- Yes  No  High Blood Pressure?

**Breathing**

- Yes  No  Asthma?
- Yes  No  Sleep Apnea?
- Yes  No  Bronchitis?
- Yes  No  Emphysema?
- Yes  No  Does patient use oxygen?
- Yes  No  Congestive Heart Failure?

**Neurological**

- Yes  No  Can patient lay flat & still for at least 2 hours?
- Yes  No  Restless leg syndrome?
- Yes  No  Parkinson's?

